

FINANCIAL AUDIT REPORT TRANSMITTAL AND COST REIMBURSEMENT FORM*(Attach to Financial Audit Report)*

The purpose of this form is to simplify tracking of the financial audit report that is required to be submitted with annual rate application(s), pursuant to CDSS Manual of Policies and Procedures (MPP), Sections 11-042.364 for Group Homes (GH) and 11-403(f)(1)(B) for Foster Family Agencies (FFA) that provide treatment services. Regardless of the number of programs, activities, and funding sources, only **one** financial audit report needs to be submitted annually by the nonprofit corporation. Since operation of more than one program funded under the Aid to Families with Dependent Children-Foster Care (AFDC-FC) may involve several applications, this form will also be used to identify all programs included in the financial audit report.

Please complete the information as requested. Attach this form and the financial audit report with either your GH or FFA rate application(s). You may retain the pink copy for your records.

Some corporations are eligible for cost reimbursement of the audit as provided in MPP Section 11-405.223. If eligible for reimbursement, submit the required documentation indicated below with the financial audit report as provided in MPP Section 11-405.221. If the documentation is unavailable, please check the box provided below, and the Financial Audits Bureau will contact your corporation.

Please submit this form with the financial audit report and rate application(s), regardless of whether your corporation is eligible for cost reimbursement.

GROUP HOME OR FOSTER FAMILY AGENCY CORPORATE NAME	CONTACT PERSON
MAILING ADDRESS	BUSINESS TELEPHONE NUMBER ()
CITY, STATE AND ZIP CODE	RATES EFFECTIVE FISCAL YEAR (FY) <input type="checkbox"/> FY 2000/01 <input type="checkbox"/> FY 2001/02
Please indicate the individual program numbers for your GH and/or FFA program(s) for which the attached Financial Audit Report includes: GH _____, _____, _____, _____, _____, _____, _____, _____ FFA _____, _____	

Please check the appropriate boxes that apply to the information that you are submitting with this form:

- ☐ **Financial Audit Report**
- ☐ **Request for Reimbursement - Eligible GH Program(s) with a combined license capacity of 12 or less, and/or an FFA, providing treatment services, with gross annual revenues up to \$765,216.**
Include:
- ☐ **Vendor Data Record, STD. 204 (REV. 2-97)**
- ☐ **Invoice(s)**
- ☐ **Proof of Payment(s), (e.g., cancelled check(s)-front and back), supporting invoice(s) paid in full.**
- ☐ **Request for Reimbursement - Documents not included**